CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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INTRODUCTION

DMAS requires that effective utilization review be maintained on a continuing basis to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate person(s). The objective of utilization review is to ensure that care is provided only when medically necessary, meets established written criteria, and meets quality standards. **Participating Medicaid providers must ensure that the utilization control requirements described in this chapter are met to receive payment from DMAS.**

NOTE: Physical rehabilitative services must be considered for termination when further progress toward the established rehabilitation goal is unlikely or it is appropriate to assume that therapy treatments can be maintained or provided by the recipient, family, care aide, etc. Specifically, if no further progress is observed, discharge would be appropriate. The physician must sign and date orders for discharge.

DOCUMENTATION REQUIREMENTS: GENERAL

For each recipient in need of outpatient physical therapy, occupational therapy, or speech-language pathology services, a physician must establish and periodically review a written plan of care. **Services not specifically documented in the recipient's medical record as having been rendered will be deemed not to have been rendered, and no payment will be provided.**

The medical record must contain sufficient information to identify the recipient clearly, to justify the diagnosis(es) and treatment, and to document the results accurately. All medical records must contain documented evidence of the assessment of the needs of the recipient, of an appropriate plan of care, and of the care and services provided; identification data and consent forms; a medical history; a report of physical examinations, if any; observations and progress notes; reports of treatment and clinical findings; and a discharge summary including the final diagnosis(es) and prognosis.

The school must maintain records on all recipients in accordance with accepted professional standards and practice. Records must be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieval and compilation of information.

All record documentation must be signed with the initials, last name, and title and be dated with complete dates (month, day, and year). A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed

by the physician. However, these methods do not overcome other requirements that are not for Medicaid purposes. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the school administration with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. The physician must initial and completely date all rubber-stamped signatures.

The medical record must include the following information:

1. Assessment/evaluation by the physician and health care professionals involved, including diagnosis, current findings, current functional deficits, clinical signs and symptoms, and needs indicating rationale for therapeutic interventions. Some of the assessment data may be found in the Individual Education Plan (IEP) or Individual Family Service Plan (IFSP.)

2. An accurate and complete chronological picture of the patient's clinical course and treatments. If appropriate, the summary of treatment rendered and results achieved during previous periods of services is included.

3. The extent to which the recipient/responsible party is aware of the diagnosis and prognosis.

4. Discharge planning must be an integral part of the treatment plan which is developed at the time treatment is initiated. The plan shall identify the anticipated improvement in functional status and the probable discharge outcomes. The recipient, unless unable to do so, or the responsible party shall participate in the plan. Changes in the discharge plan shall be entered into the record as the changes occur.

   Services must be considered for termination regardless of the preauthorized visits or services when any of the following conditions are met:

   - No further potential for improvement is demonstrated.
   - There is limited motivation on the part of the individual or the caregiver.
   - The individual has an unstable condition that affects his or her ability to participate in the plan of care.
   - Progress toward an established goal(s) cannot be achieved within a reasonable period of time.
   - The established goals serve no purpose to increase meaningful functional or cognitive capabilities.
   - The service can be provided by someone other than a skilled health care professional.

5. Each discipline must prepare a discharge summary when the recipient’s treatment plan is completed or at any time discharge occurs. The summary must document the recipient’s progress relative to treatment goals and must identify goals that were and were not met. Recommendations for future care, as appropriate, must be included.

Current medical records and those of discharged recipients must be completed promptly. All clinical information pertaining to a recipient must be centralized in the recipient's clinical record. Each physician's entry into the record must be signed and dated by the physician making the entry.

The school must recognize the confidentiality of medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern records' use and removal and the conditions for the release of information. The recipient/responsible party's written consent is required for the release of information not authorized by law.

Records must be retained for not less than five years after the date of discharge. Records must be indexed at least according to the name of the recipient to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The school must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval).

DOCUMENTATION REQUIREMENTS: PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES

Physician's orders for all services shall include the responsible discipline, treatments, modality, frequency, and duration. The physician's order must be renewed annually for non-acute services. If the components of the physician's orders are included in the plan of care, a separate order is not necessary. **Physician orders must be personally signed and dated by the physician within 21 days of the implementation of the plan of care.**

A plan of care specifically designed for the recipient by the physician after any needed consultation with the therapist(s) or other health care professional must be available for all recipients. Use the "Physician Authorization for Services and Therapist's Plan of Care" (MED 8) for this purpose. (See "EXHIBITS" at the end of this chapter for a sample of this form.) This plan includes measurable goals (long- and short-term) which describe the anticipated level of functional improvement together with time frames for improvement and/or goal achievement. Included are therapeutic interventions to be addressed by the therapist or other health care professional. The plan of care must be personally signed and dated by the physician and the therapist.

Staff must write progress notes for each visit. Documentation in progress notes must be in accordance with the plan of care. Progress notes must be signed and dated by the professional providing the treatment or care. Documentation must be available that all treatment is rendered to the recipient in accordance with the plan of care with specific attention to frequency, duration, modality, response, and identification of who provided care. Use the "Therapist's Notes" (MED 9) for this purpose.(See "EXHIBITS" at the end of this chapter for a sample of this form.) Any changes in the recipient's condition must be noted with subsequent revisions in the plan of care made. This includes revision of long-term goals, establishment of new long-term goals, and termination of long-term goals achieved. Use the MED 8 and MED 9 and/or "Plan of Care Addendum" MED 12 (See

"EXHIBITS") to document changes. Flow sheets or check lists may serve as data collection methods to augment progress notes.

The plan of care may be prepared and signed by the therapist and sent to the physician for signature. The plan of care must subsequently be reviewed by the therapist and the physician as required and is either revised and signed at that time or is signed without revision indicating the plan is appropriate and needs no revision. Revisions are goal-determined.

DMAS UTILIZATION REVIEW RESPONSIBILITIES

Utilization controls are important in ensuring high-quality care as well as the appropriate provision of services and the medical necessity for services. Many of the review and control requirements respond to federal regulations; all participating providers must comply with the requirements.

Under federal regulations, the Department of Medical Assistance Services must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes the review of the utilization of services rendered by providers to recipients.

DMAS staff will perform desk or on-site utilization review to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patients' medical records as having been rendered will be deemed not to have been rendered, and no reimbursement will be provided.

Periodically, utilization review analysts from DMAS will visit each enrolled school division, review the medical records, and conduct an overall review of the provision of services with respect to the:

- Comprehensive care being provided;
- Adequacy of the services available to meet the current health needs and to provide the maximum physical and emotional well-being of each recipient, including the safety and sufficiency of space available for the scope of services offered;
- Necessity and desirability of the continued stay of the recipient;
- Feasibility of meeting his or her health needs in alternate care arrangements; and
- Verification of the existence of all documentation required by Medicaid.

CRITERIA FOR REIMBURSEMENT

Rehabilitative services that fail to meet Medicaid criteria are not reimbursable. Such non-

reimbursable services will be denied upon preauthorization or at the time of DMAS utilization review activities. Medicaid criteria for general reimbursement of general outpatient rehabilitation in schools are found throughout the provider manual and include, but are not limited to, the following:

- A signed and dated physician order to the provision of service;
- A plan of care prior to the provision of services including the assessment and identification of deficits and outcome recipient goals;
- The service must address the identified, medically necessary, functional goals;
- Additional services are expected to substantially improve functional ability or health care status;
- Significant progress toward goals within a reasonable period of time;
- Documentation available for services rendered and/or billed;
- Renewal of the physician order annually for non-acute sevices; and
- Evaluation/re-evaluation related to the admission to service, to readmission to service, or to a major change in the condition of the recipient and which is not provider-program mandated.

The Department of Medical Assistance Services routinely conducts utilization review to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. Participating Medicaid providers are responsible for ensuring that requirements, such as record documentation for services rendered, are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request.

Providers and recipients are identified for review either from systems-generated reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Some provider reviews are initiated on a regular basis to meet federal requirements (for example, nursing facilities are reviewed twice a year). DMAS reviews claims for services provided by or resulting from referrals by authorized PCPs in managed care and utilization control programs. In some programs, random sampling may be used to determine areas for on-site reviews. There are also computerized exception reports which look at utilization patterns for providers and recipients. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. Exception reports for recipients are developed by comparing individual recipient's medical services utilization with those of the recipient peer group. An individual exception profile report is generated for each recipient and provider who exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all

cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary. Statistical sampling may be used in a review.

The use of statistical sampling is recognized as a valid basis for findings of fact in the context of Medicaid reimbursement. DMAS may utilize a scientific random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the number and amount of invalid dollars paid in the audit sample is compared to the total number and amount of dollars paid for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to regulation or statute, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Corrective actions for recipients include education on the appropriate use of health care, restriction to designated providers for utilization control, recovery of misspent funds, and referral for further investigation of allegations of fraudulent activities. Loss of Medicaid coverage can result from a conviction of Medicaid fraud.

REFERRING RECIPIENTS TO CLIENT MEDICAL MANAGEMENT

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) in the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program (CMM). If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589
FAX: (804) 786-5799

When making a referral, provide the name and Medicaid number of the recipient and a brief statement regarding the nature of the utilization problems. Hospitals continue to have

the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Provider Restriction

Federal regulations in 42 CFR 431.54 (f) allow states to restrict providers from participation in the Medicaid Program when the provider has provided items or services at a frequency or amount not medically necessary or has provided items or services of a quality that does not meet professionally-recognized standards of health care. State regulations in VR 460-04-8.3 allow DMAS to restrict providers' participation as designated providers, referral providers, or covering providers for restricted recipients when a provider has billed services at a frequency or level exceeding that which is medically necessary or when a provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.

Any pharmacy enrolled as a community pharmacy billing on the Daily Drug Claim Ledger may serve as a designated pharmacy unless the pharmacy has been notified by DMAS that it may not serve as a designated provider.

Any physician enrolled as an individual practitioner may serve as a designated primary care provider except when:

- The physician's practice is limited to the delivery of emergency room services; or
- The physician has been notified by DMAS that he or she may not serve as a designated provider or referral provider for restricted recipients.

Provider restriction is for 18 months. Providers may appeal any proposed restriction in accordance with the *Code of Virginia*, Section 9-6.14:11 et seq., as discussed in Chapter II of this manual. Restriction is not implemented pending the result of a timely appeal request.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Since payment of claims is made from both State and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or State court. The Program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the

appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 692-0480
FAX: (804) 786-0414

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

Allegations regarding issuance of non-entitled benefits and/or fraud and abuse by non-providers are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid and/or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card-sharing and prescription forgeries.

If it is determined that non-entitled benefits were issued, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of

Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of 12 months beginning with the month of the fraud conviction. The sanction period may only be revoked or shortened by court order.
Referrals should be made to:

Supervisor, Recipient Audit Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-0156
FAX: (804) 225-4393

EXHIBITS

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School Division: _____

Plan of Care
Physician Authorization for Rehabilitation Services
(Fully complete all sections.)

1. STUDENT NAME: _____ 2. DOB: _____

3. Medicaid#: ☐☐☐☐☐☐☐☐☐☐☐☐

4. Physician: _____ 5. Physican's Phone: _____

6. Diagnosis: _____ ICD-9 Code: ☐☐☐.☐☐

7. Child's Functional Deficits: (Be specific.) _____

_____

_____

8. Summary of Previous Treatment: (Relative to goals.) _____

_____

_____

_____

9. Long Term Goals/Objectives: (include anticipated level of achievement by end of school year.)

_____

_____

_____

_____

_____

10. Plan of Care
Discipline: ___ SLP ___PT ___ OT

Frequency:
Individual: ____X/ _____
Group: ____X/ _____

Interventions, treatment, modalities: (Be specific.) _____

_____

Date Treatment Plan will be implemented: _____
Month/Day/Year

Med-8/95-96 (front)

11. Discharge:

Discharge Goal: _____

Discharge Plan (functional outcome):
___ Independent Home
___ Independent with assistive device(s)
___ Requires assistance
___ Requires supervision
___ Dependent

Discharge Disposition:
___ Home ___ Hospital
___ Other (specify)

_____

Anticipated Discharge Date: _____

12.

_____ _____
Signature of Therapist (Title) Date

_____ _____
Signature of Physician Date

Instructions for Plan of Care

1. Recipient's last and first name
2. Full date of birth (Month, day, year)
3. Complete Medicaid number (12 digits)
4. Name of physician authorizing plan of care (services)
5. Telephone number of physician
6. Diagnosis related to rehabilitation therapy prescribed; include educational disabilities and ICD-9 code.
7. Enter functional deficits related to therapy prescribed; clinical signs and symptoms; deficits indicating therapeutic interventions.
8. Enter chronological picture of clinical course, summary of past treatment, and results of progress achieved during the most recent period of treatment. Thereafter, response to treatment is entered once a year when the plan of care is updated and sent to the physician for review and signature.
9. Enter long term goals/objectives, stated in functiona loutcomes (measurable), from the I.E.P.. Describe the anticipated level of functional improvement together with time frames for anticipated improvement and/or goal achievement.
10. This section contains the physician's order and must identify the discipline, treatment, modality(s) and frequency. Enter therapeutic interventions to be provided by the therapist. Enter date treatment will begin relative to *this* plan. (Not when the therapy began during the school year.)
11. Describe the child's anticipated function. Check the most appropriate expected outcome and expected destination. Identify the anticipated discharge date. (Discharge refers to final termination of therapy and does not apply to the end of the school year.)
13. Provide signature and professional designation (title). Dates must be complete for month, day and year.Physican must sign within 21 days of the date the plan of care will be implemented in order for billing to begin on date therapist signs.

School Division: _____

Therapist's Monthly Notes

_____ _____

Student Name Medicaid #

Month/Year: _____ Therapy: ___ PT ___ OT ___ Speech

Therapy Activity/Date

Key: ✔ = Individual Therapy X = Group Therapy

Short Term Objectives:

_____

_____

_____

_____ _____ _____

Therapist/Asst.. Signature and Title Therapist/Asst. Printed Name and Title Initials

_____ _____ _____

Supervising Therapist Signature and Title Supervising Therapist Printed Name and Title Initials

Date	Activity	Results	Init.

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Date	Activity	Results	Init.

Instructions:

▲ Use the key to enter individual or group therapy. Date each keyed activity.

▲ List the short term objectives which will be addressed during the month. An objective may be longer than 30 days and will carry over each month until the objective is met. Objectives should be measurable and include date objective is expected to be accomplished..

▲ Fill in the date, activity, measurable results sections each time a child receives therapy.

▲ Each therapy session is to be initialed.

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School Division _____

Plan of Care
Addendum
Physician Authorization for Rehabilitation Services

1. _____ Student Name

2. _____ DOB

3. _____ Medicaid Number

4. _____ School

5. _____ Diagnosis

5. _____ ICD-9 Code

6. Change to Original Plan of Care (include reason for change)

_____

_____

_____

_____

_____

_____

7. Discipline: ___ Speech ____ PT ____ OT Frequency: Individual ___x_____
Group ___x_____

8. Date Plan of Care Addendum will be implemented: _____

9. _____ _____
Signature/Title of Therapist Date

10. _____ _____
Signature of Physician Date

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